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## **Joined-up thinking, joined-up services, exploring coalface challenges for making services work for families with complex needs**

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### **Abstract**

**Purpose:** This article describes coal-face challenges to making services in the UK work to ensure the mental and physical health, safety and wellbeing of children.

**Methodology/Approach:** After briefly referring to some challenges to effective joined-up service provision, it describes examples from the first author's experience of problems, during 30+ years as an NHS clinical child psychologist, and some solutions. It then describes two challenges that underpin many of these problems: lack of understanding of, or training in, evaluating evidence for interventions and a more general lack of knowledge about effective behaviour change principles. **Findings:** The paper concludes with recommendations about how to achieve effective joined-up services. Common themes emerging from the research are discussed, including choosing evidence-based programmes, providing adequate training to staff, and increasing people's understanding of behavioural principles.

**Originality/Value:** Having effective joined-up services would mean better services for parents and their children, and would be more cost-effective for the NHS. The ideas presented in this article could also be applied to other services within the NHS.

**Keywords:** children, collaboration, evidence-based practice, families, professional practice

**Abbreviations:** NHS, National Health Service; CAMHS, Child and Adolescent Mental Health Service; ASD, Autistic Spectrum Disorders; ADHD, Attention-Deficit Hyperactivity Disorder

### **Introduction**

Ensuring that services to families are co-ordinated and effective presents administrative and professional challenges. The death of Maria Colwell in 1973 (Field-Fisher, 1974) identified a lack of information sharing between agencies and resulted Child Protection registers. However, more recent enquiries into the deaths of Victoria Climbié (House of Commons Health Committee, 2003) and baby Peter (The Lord Laming, 2009) have demonstrated continuing failure to get co-ordinated services. Furthermore, child protection referrals in the UK increased by 6% in 2009/10 over the previous year (Brooks and Brocklehurst, 2010). Although the reasons for this increase are unclear it might in part have been driven by worker anxiety following the criticism of service providers after the death of baby Peter, however job losses and economic collapse in 2008 would have also put increasing numbers of families into stressful circumstances associated with increased risk to children. Regardless of cause, the need to address challenges to joined up service provision and find solutions remains pressing. The literature mostly focuses on 'service delivery disasters' particularly in relation to children (Frost, 2005; Dunleavy, 2010; Dunleavy *et al.*, 2010) with relatively little discussion of everyday challenges for workers on the coal-face.

Although there are many and varied challenges to effective joined up service provision, from the first author's perspective, based on clinical experience from over 30 years, the following 10 challenges seem particularly salient:

*Theoretical/definitional issues:*

1. A mismatch between policy initiatives from different departments at Government level or even within Departments.
2. Philosophical and professional differences produce different explanations for problems resulting in disagreements about treatment/intervention strategies. Problems can be viewed as illnesses, criminality or inappropriate learning/lack of opportunity to learn appropriate behaviour.
3. Lack of agreement about what constitutes risk, particularly, but not only, in the area of child protection. The identification of risk can involve a range of professionals with differing expertise; police, health, education and social care staff.

*Administrative issues:*

4. Problems for local strategic planning, and management of services, in collaborating across a plethora of statutory and voluntary agencies around joint record keeping, referral processes and information exchange.

*Process issues:*

5. Issues regarding decisions about who has access to what information. The 'need to know' basis for information sharing can be construed differently by different agencies.

*Practice issues:*

6. Lack of knowledge about what works and how to identify and select evidence-based interventions.
7. Even when an evidence-based intervention is used there can be failure to ensure that staff have the necessary intervention skills, time, supervision and resources to deliver it effectively (Author's own, 2007a).
8. Lack of training in effective behaviour change principles needed to engage service users. This applies to most professional training, in teaching, social work, nursing and medicine, where behaviour change, academic engagement, weight loss, substance misuse reduction and improved parental monitoring of children are intervention goals but effective behaviour change skills are not taught.
9. Lack of managerial systems to detect institutional bad practice. Even in residential settings, with many staff present, abuse takes place, as was identified in the North Wales Children's Home Inquiry (Waterhouse *et al.*, 2000).
10. Lack of knowledge about interventions delivered by other professionals.

The above 10 challenges manifest themselves in six coal face problems as follows:

**1. Differing philosophies and understanding of the nature of problems**

Each edition of the Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association, 2000) adds new mental health diagnoses and disagreements about whether a problem is a medical condition or a learned behaviour, or their relative

contributions, are not uncommon. The medicalisation of child behaviour problems is particularly prevalent in the US where, without a diagnosis, treatment is not covered by insurance and where levels of prescribed psychotropic medication for children are dramatically higher than in the UK (Parry and Levin, 2011).

Fortunately, in the UK, diagnosis of Child Conduct Disorder, a DSM-IV classification, results in recommendation of a psychosocial intervention, parenting, by the National Institute for Health and Clinical Excellence (NICE, 2006) so the potential conflict about whether it is a clinical condition or a learned behaviour is reduced. This approach is becoming more widespread and both the Government and NICE now recommend non-medical interventions for diagnosed conditions as part of the approach to Increasing Access to Psychological Therapies (IAPT).

The demand for diagnosis can come from parents. This not only removes perceived blame but can lead to, often much needed, financial benefit for families living in poverty with the award of Disability Living Allowance for the child. There can also be conflicting advice about particular challenging behaviours. Parents of children with diagnoses of Aspergers, Autistic spectrum or other developmental difficulties have reported being told that problem behaviours, such as aggression and non-compliance, are part of the condition. These children face additional challenges in learning socially appropriate behaviour, however in our experience, many families have been supported in identifying and teaching new achievable skills to replace some of their children's more challenging and often antisocial behaviours. This can be successful whilst acknowledging that these children will always face challenges. Left untreated such problems doubly handicap these children.

## **2. Keeping very vulnerable families engaged in services**

A mother of four in an early intervention parenting trial (Author's own, 2007b) left a child in the crèche. The family were on the child protection register and, despite reservations, after a home visit, she had agreed to participate. After the initial session, she went to collect her child from the crèche and returned, in a state of distress, saying "I'm not leaving a child of mine there again". She had been informed of her child's unacceptable behaviour in front of other parents and felt embarrassed. She said "It would have been fine if they had talked to me when no-one else was present". It was a newly established nursery with both paid and volunteer staff. We agreed to run the parenting programme for the staff. During a session on nursery rules, it became apparent that swearing was dealt with by a telling off, time on a 'naughty' chair, being told not to use that word or ignored. Discussion about consistency was helpful. A statement that "That is not a nursery word" followed by giving attention to other children for using friendly words was found by staff to be effective in changing such behaviour. Staff learned that it was inappropriate to punish a child for using language that was sanctioned outside the nursery setting and that the goal was to teach and attend to more appropriate alternative behaviour. The course was well received and, since 2004, many nursery staff across Wales have attended similar courses. A small grant enabled us to run and evaluate the parenting programme with staff from two Flying Start nurseries (The Welsh Government, 2009) showing significant improvements in child behaviour and nursery staff confidence (Author's own, 2011a).

## **3. Working together with child protection families**

Work with families where there is concern about risk to children is extremely challenging for all professionals however there is growing recognition that parenting programmes can contribute to positive outcomes (Webster-Stratton and Reid, 2010; Hurlburt *et al.*, 2013) and are increasingly mandated by courts. Nevertheless achieving positive outcomes from parenting programmes requires significant planning as demonstrated in the following examples:

i) Ensuring that all staff understand the nature of interventions being provided

A problem occurred for a parent attending a parenting course as part of the plan to return her child from foster care. Given the assignment-based nature of the parent programme, parents need weekly access contact with their children. This is a condition of attendance. Effective parent training courses are not theoretical. However weekly supervised contact, was not with the same supervisor each week. One contact supervisor reprimanded the mother for ignoring her child. “But” she said “I was not ignoring my child I was ignoring an unwanted behaviour and giving attention to behaviour I wanted to see more of.” This “differential attention” principle is an important component of most effective parent programmes. This powerful and non-aversive strategy helps children to learn how to behave.

Contact supervisors must be familiar with the intervention and support parents in their practice assignments. One solution is for contact supervisors to attend the programme with, or without, the parent that they supervise. This, and the next example, highlighted the need to plan how to work with agencies on child protection plans that include a parenting component, and resulted in information sessions for staff on programme content, structure and assignment details.

ii) Location of contact visits

One parent attending a parent group had supervised contact in a local fun centre, an incredibly noisy environment with parents sitting at a couple of tables watching noisy, hyperactive children. Whilst the children liked going there, it did nothing for the parent/child relationship and was unrelated to any discernable contact goal so a more suitable domestic environment was identified.

iii) Ensuring clear goals for interventions

Many staff running parent groups are expected to accept parents with child protection concerns without clear specification of the goals for attendance. A father was attending a group but not participating, standing at the back of the room with his baby in a carry-seat on the floor, despite the availability of a crèche. He came late or inconsistently to sessions, did not contribute to discussion or report back on home activities. He and his partner started the parent programme without clarifying a goal for their attendance. The father said ‘I am doing what they said and coming!’ At a one-to-one meeting, we explained that what the father was doing would not help him. Attendance meant arriving on time, participating in discussion and doing and reporting on home activities. It was also important that they understood that positive engagement with the group would be helpful, but was not evidence of their actual behaviour with the child, neither did it necessarily address the actual risk, which had not been clearly explained to either the group leaders or the parents. This highlighted the need to ensure that both parents and group leaders understood the perceived risk, what goals of the plan would be met by group attendance and what role the group leader had in relation to feedback.

iv) Parents with special needs

Parents with learning difficulties can be subject to child protection procedures and, as above, this needs co-ordinated planning. Attending parent groups with their support worker who also undertakes weekly visits to support the home activities helps many participants who otherwise find home-based practice challenging. Whilst participation in group sessions is important it is what parents do at home that makes the difference (Author's own, 2004) but this is challenging for many parents so additional scaffolding, from weekly home coaching, can be essential.

v) Evaluating different sources of evidence

One challenge, in child protection decisions, is how to weigh competing evidence. This was highlighted with a family where health visitor concerns were mainly around hygiene issues, such as an unemptied pot of faeces in the living room. However videotaped observation of the parent-child interaction demonstrated a strong positive mother-child bond so the hygiene issues were put into context and problem solved. This was shared with the parent, along with positive feedback, and a plan to improve hygiene agreed. She recruited a neighbour to check daily and record examples of poor hygiene. This helped her to learn what concerned others and to improve on it. The family were quickly removed from the register.

#### **4. Working with foster carers**

The first author had worked with many foster carers who had CAMHS referred children placed with them and had seen them benefit from attending a parenting group. Eventually we obtained funding for a small trial of the Incredible Years (IY) parent programme, specifically with carers. Three Authorities in Wales ran the programme and participated in a small research trial. Challenges included that children were aged from 1 – 17 years. Nevertheless the trial worked well, carer stress and depression improved, as did child behaviour (Author's own, 2010). Specific issues from supervision such as, for some, the impossibility of expecting, in the short term, the same behaviour as they did for their own children and how to handle this have been written up (Author's own, 2012a). Carers in one group were also attending an attachment training course and the leader told them that the IY parenting programme was inappropriate for looked-after children (LAC) because it included Time Out (TO) as part of the discipline plan. This view is understandable since there are many different approaches to TO as demonstrated by Super Nanny, however the leader of the attachment programme was not knowledgeable about the IY parent programme which is an attachment based approach where the main emphasis is on play, relationship building and coaching social and emotional regulation skills. Neither did they understand that within this programme TO is taught as a structured ignore giving the child a brief time away to learn to self-regulate. This is often in the same room with the parent/carer remaining present and is terminated with redirecting to another activity and praise. This approach is based on a substantial body of research (Author's own, 2012b; Foxx and Shapiro, 1978). It is short, generally not more than five minutes, supervised and terminated with re-engagement and positive attention. Parents are taught that it only works if, for the rest of the time, the child is in 'time in' the sunshine of positive attention and alternative behaviours are being taught and reinforced.

Carers were not given an alternative discipline plan by the attachment trainer and, since failure to manage the children's challenging behaviour causes most placement breakdown (Author's own, 2011b), it was distressing for carers to be put in this conflict situation. Effective programmes give parents tools to strengthen relationships and positive behaviour **and non-aversive strategies to manage problem behaviour** (Author's own, 2004; Malott and Trojan, 2007). The principle, that was ignored, was the need for professionals to discuss differences and misunderstandings rather than give service recipients conflicting advice. Attachment difficulties are important, which is why attachment is the foundation of the IY parent programme; furthermore there is solid evidence emerging that the IY parenting programme reduces behaviour problems and independently strengthens attachment relationships (O'Connor *et al.*, 2013).

Other difficulties arose when leaders were not part of the LAC service and carers had volunteered for the IY parent programme. Leaders had some concerns about one carer, although this did not amount to child protection concerns, but had not established, prior to the group, what information should/could be given to the LAC team. Another difficulty, for the same leaders, was not having sufficient knowledge about the rules for carers in relation to pocket money, *'we have to give it to them because it is provided by the LA even if we don't like what they will spend it on – cigarettes, etc'* or what were acceptable sanctions. These problems are easier to deal with if a member of staff from the LAC service is part of the delivery team, although some services had no guidelines on some of these issues.

### **5. Selecting evidence based programmes and delivering them with fidelity**

Choosing an evidence-based programme is not easy when hundreds of programmes are available. The National Evaluation of Sure Start (NESS, 2005) in England is a good example of how difficult it is. The Sure Start initiative was launched in 2001 and by 2006 £3.1 billion had been invested in it (Meadows, 2006). However, central Government had failed to specify effective interventions meaning that service providers delivered widely differing services, with some delivering evidence-based programmes and others developing their own (Belsky *et al.*, 2006). As a result, an evaluation of the first three years of the intervention showed no benefits for the most disadvantaged families (Belsky *et al.*, 2006; Author's own, 2007b).

Since the initial NESS report, the UK Governments have being more directive by specifying the use of parenting interventions with evidence of effectiveness. There are now sources of information regarding effectiveness of parenting programmes available. One source is the Blueprints for Violence Prevention compiled by the Center for Violence Prevention, University of Colorado. They use strict criteria to categorise programmes based on their quality as either model or promising 'Blueprints'. Only 30 of 900 programmes reviewed achieved at least promising 'Blueprint' status. In the UK the Commissioning Toolkit developed by the National Academy of Parenting Practitioners and now hosted by the Children's Workforce Development Council is another good source of evidence for programmes for which training and resources are available in the UK ([www.commissioningtoolkit.org](http://www.commissioningtoolkit.org)).

Whilst it is important to choose an evidence-based programme, it is also important to ensure that the programme is being implemented properly. 'Implementation Science' is the field of study concerned with what is needed for effective research-based programmes to be delivered

with equal effectiveness in service settings. Guidance on effective delivery in service settings comes from the Society for Prevention Research (SPR, 2004) and the National Institute for Health and Clinical Effectiveness (NICE, 2009). 'Fidelity' involves the programme being delivered as initially researched and with all of the essential requirements. A programme is suitable for dissemination if it contains all that is needed for others to achieve the same results (Mihalic *et al.*, 2002) and includes - levels of prior skills, training, supervision and resources.

Fidelity in parenting programmes means addressing access, content and process or delivery skills (Author's own, 2004). Fidelity failure can arise from any of these.

i) *Access* - involves recruitment resources, transport, timing and crèche facilities. Disadvantaged families have few resources so gaining access to services can be difficult. Special attention needs to be given to access issues to make their attendance more likely. In our early intervention Sure Start work (Author's own, 2007b) access issues were dealt with by providing transport when needed (i.e. taxi), providing crèche facilities, and providing lunch either before or after the group meeting. This was a great way for group leaders to develop good relationships with attending families. Providing crèche, transport and a meal made programme access feasible for disadvantaged high-risk families and probably contributed to the high attendance and programme completion rates. As our Sure Start trial showed, with adequate resources trained staff retained high challenge parents, 83% attended more than 2/3rds of the programme (Author's own, 2007b).

ii) *Content* - involves delivering all of the key ingredients of the programme, including number of sessions, the same target population, etc. Ensuring that evidence-based interventions are effective means delivering the programme as it was originally intended. If the intervention is not delivered entirely or adapted in some way it can reduce the effectiveness of the intervention. Some of the key components of evidence-based parent interventions include: active rehearsal of behaviours using approaches such as role-play, and videotape feedback; teaching principles rather than techniques to ensure that parents have the necessary tools to decide what works best for them; the inclusion of non-violent sanctions for negative behaviour as well as strategies to build positive relationships (Author's own, 2004). Programmes should include materials for parents (including homework), catch-up sessions if a parent has missed a session, and records of material covered in each session to ensure fidelity.

iii) *Process* - involves ensuring that a programme is delivered collaboratively, that parents engage with the programme and that it meets parents' goals. Learning the content of an evidence-based parent programme is necessary but leaders are also helping each parent to set and achieve realistic developmentally appropriate and achievable weekly goals so need knowledge about the challenges facing the children. In North West Wales, health visitors and early intervention staff work with preschool children and CAMHS and Specialist Children's Services staff working with the parents of older children with significant problems and a range of diagnoses. CAMHS based groups include parents of diagnosed children with development delay, conduct disorder, ASD, ADHD, obsessive compulsive disorder, etc.. However some CAMHS services refer such parents to community based services where staff may not have the experience to provide the scaffolding needed for parents (and children)



to succeed. There can be a mistaken view that, because parenting programmes are manualised, people can deliver them to any parent. The core parenting toolkit is common to all and based on well-established principles but, to be successful, the way it is used must be tailored to the needs of the individual participants (Webster-Stratton and Reid, 2010).

### **Addressing recruitment of hard to engage people to services, lessons from CAMHS experience and from the Sure Start trial**

Families facing the greatest challenges can be hard to engage in services but the service providers must take the responsibility for motivating and retaining families in the interests of their children. During initial delivery of a parenting programme in the local CAMHS service there was difficulty in recruiting parents. Many parents had waited months for their child to be seen only to be told to attend a parenting programme. CAMHS staff were trained to start by acknowledging the child's difficulties and then explore how these problems made the child harder to parent. They then explained how, because of the time parents spend with children they were the most effective source of support. Referring staff also learned the content of the programme and acknowledged that the programme may not solve all of their child's difficulties. Giving parents an opportunity to talk with a former participant was also incorporated. They are often the best advocates for the programme. We also made a short film of Welsh parents talking about their experiences of attending the IY parent programme. Once parents made a provisional commitment they met a group leader so were not coming to a group without knowing anyone. This prior meeting also helped the group leader to learn about specific challenges faced by the child and access issues, including crèche and transport. Together these strategies resolved the recruitment problems.

This approach was used in our early intervention Sure Start work. We recruited a research health visitor (HV) to work with frontline HVs and train them in recruitment. We recruited very high challenge families, young and/or single, depressed or socially disadvantaged parents and those whose children had the greatest problems, and their outcomes were as good as those for families facing less challenges (Author's own, 2010). Once parents enrol the issue becomes one of keeping them on board. Getting what they came for is the key to retention, i.e. identifying an achievable goal that the parent holds and delivering it (Goldiamond, 1974).

### **Discussion**

A number of common themes emerge from the examples above.

- i) The need to ensure the choice of evidence-based programmes where they exist. This involves training service providers in the skills to evaluate sources of evidence as has recently been highlighted in the Geek Manifesto by Mark Henderson, Head of Communications at the Wellcome Trust (Henderson, 2012). This discussion has further been advanced in the Cabinet Office publication 'Test Learn Adapt' that describes the qualities of evidence that are rigorous and how to ensure that data is collected to enable an evidence base to be established for interventions (Haynes *et al.*, 2012).
- ii) People delivering interventions must be suitably skilled, resourced and supervised in the intervention. This involves training in specific interventions and the provision of necessary resources to enable it to be delivered as developed, with time and resources that enable

participants to access the service. It also requires that the service providers have appropriate background knowledge to engage people in achieving their own goals (Mihalic *et al.*, 2002).

iii) All people involved with a family or service user must be knowledgeable about the intervention being delivered and the underpinning principles and activities. We have worked at a local level by putting on training for support staff in core principles, trained nursery staff, and delivered workshops for managers. We have also supported leaders, through supervision, in setting ground rules about accepting referrals to groups and obtaining relevant information when asked to have parents on child protection registers. At an all Wales level, with Welsh Government funding, we have developed a strategy for the development of an evidence-based parent, child and teacher programmes that include basic training and on-going supervision, to ensure consistency among professional staff in working with families. This work has been funded by the Welsh Government since 2006 (Author's own, 2012b).

iv) There is a general lack of understanding of the principles of behaviour change that have come from over 50 years of research into human learning (Skinner, 1971) and are continually being advanced (Malott and Trojan, 2007). This is not a core part of much professional training, despite its relevance to people working in the criminality, education, health and social care fields. The need for better knowledge about effective ways to support people in changing behaviour applies much more generally than in the examples given above. Many problems dealt with by the NHS are lifestyle problems, including poor diet, lack of exercise, alcohol consumption and smoking that result in cancers, cardio-vascular problems, diabetes and many other physical and mental health difficulties. In 2005 the number of deaths attributable to smoking, one of the biggest avoidable causes of morbidity and mortality in the UK, was over 100,000 (19% of all deaths) and the direct cost to the NHS in 2005–6 was £5.2 billion (Allender *et al.*, 2009). More recently the NHS costs of drugs to deal with lifestyle diseases, including obesity, diabetes, alcoholism and smoking have been estimated at £750m, with obesity now costing more than any other disease, due to an explosion in type 2 diabetes diagnosis associated with increasing obesity levels (Smith, 2012) so knowledge about behavior change principles is much needed. Another core skill is knowledge about motivational interviewing, how to help people engage in a behaviour change process. Similarly this is not new science (Rollnick *et al.*, 1992) and is highly relevant to the process of engaging people in developing new skills and coping strategies (Rollnick *et al.*, 2007).

## Conclusion

This article has drawn examples from experience of using evidence based parenting programmes in a child mental health service. Some of the identified solutions to achieve better joined up services include:

1. Choose evidence-based programmes using the best available knowledge. In the field of parenting in the UK we have the parenting toolkit funded by the Department of Education.
2. Ensure that the fidelity issues are understood and staff are adequately resources and skilled to deliver to the target population (SPR, 2004; Mihalic *et al.*, 2002).
3. Train all service staff in what is included and the theoretical underpinning of interventions to ensure that service user are not given conflicting advice.

4. In relation to child protection work not only must service users be clear as to the reasons for referrals of families to parenting programmes but families need to know the goals of the referral and what they need to do to impact on outcomes.

In relation to the first author's own work, some solutions to these challenges have been achieved through selecting evidence based programmes, demonstrating local evidence, setting limits around referrals and ensuring that service users and professionals understand the content and goals of the intervention (Author's own, 2012c). This has also involved work to ensure that services are client ready and accessible and that service users were helped to identify and achieve their own goals.

#### **Summary of policy and practice implications**

- There is urgent need for services to provide evidence-based programmes to children and their families. Training service providers in skills necessary to evaluate available evidence is essential for this to happen.
- Delivering evidence-based programmes is a good start however if these are not delivered with fidelity they may not be effective. Ensuring the sufficient training of staff would mean better levels of fidelity.
- Increasing service providers and staff knowledge and understanding of behavioural principles, which are the basis of many effective evidence-based programmes, could also help co-ordinate services for children and families.

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